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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Sep/06/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Chronic Pain Management Program 5x2 weeks

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Pain Medicine

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. The reviewer finds Chronic Pain Management Program 5x2 weeks is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 07/20/12, 08/14/12
Request for reconsideration dated 08/07/12, 04/23/12
Request for services dated 03/16/12
PPE dated 04/03/12

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a female whose date of injury is xx/xx/xx. Request for services dated 03/16/12 states that the patient has completed a course of individual psychotherapy. BDI increased from 29 to 38 and BAI decreased from 17 to 15. PPE dated 04/03/12 states that the patient lifted a heavy tray full of mail when she suffered an injury to her right shoulder and lumbar spine. She has been treated with x-rays, physical therapy, MRI of the right shoulder, right shoulder injection, MRI of the lumbar spine, right shoulder surgery on 10/06/11 and medication management. Denial dated 08/14/12 notes that the patient was authorized for 10 visits of work conditioning program, which has already been performed. There is no evidence of progress with objective functional improvements from the prior program already provided. The evidence based guidelines do not support repeating the same or similar program for the same work injury, such as the current request following the completion of a work conditioning program. The guidelines do not support using a chronic pain program as a stair step program following a lower level of care program which is the case with this claimant. The submitted PPE is over x months old. A recent PPE has not been performed or provided with

findings present to support the current request with evidence of max valid effort.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
There are no treatment records submitted for review to establish that this patient has exhausted lower levels of care and is an appropriate candidate for this tertiary level program as per the ODG. The submitted PPE is nearly x months old, and there is no current PPE submitted for review. In addition, this patient previously underwent a work-conditioning program; however, the patient's objective, functional response to this program is not documented. It is unclear whether the patient has undergone any recent treatment or been compliant with a home exercise program. The reviewer finds Chronic Pain Management Program 5x2 weeks is not medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)